Screening Questionnaire—Injectable Influenza Vaccination

Legal Name: (Print) ____ Phone Number: __________________

Mailing Address: _________________________________ City: ________________ Zip Code: _____________

Date of Birth: _________________ Gender: M F Mother's First Name: _________________________

		Yes	No
1.	Are you sick today?	___	___
2.	Do you have an allergy to eggs or to a component of the vaccine?	___	___
3.	Have you ever had a serious reaction to influenza vaccine in the past?	___	___
4.	Have you ever had Guillain-Barré syndrome?	___	___
5.	Are you pregnant?	___	___

Please check one

☐ Medi-Cal/CHDP ☐ No Insurance ☐ American Indian/Alaskan Native ☐ Private Insurance

Signature: ____ **Today's Date:** _______________________

For Staff Use Only:

☐ Second Dose Required (under 9 only)

Nurse: __________________________________ Site: ☐ RD ☐ LD ☐ RT ☐ LT

CAIR # __________________________

Revised 7/23/15